care UK

NHS

Direct Referral to Will Adams NHS Treatment Centre
Cataract Surgery

Date: / /

Referring Practice	Patients's GP	Patient Information
	Dr.	Name:
		Gender: ☐ Male ☐ Female
		DOB:
	Practice Address:	Height: Weight:
		NHS Number:
		Telephone Number:
		Mobile Number:
		Address:
		Postcode:

Examination Findings

	Right	Left
Visual Acuity		
Refraction		
Cataract Found	Yes/No	Yes/No
Lids		
Cornea	Clear	Clear
Anterior Chamber Depth	Narrow/Deep	Narrow/Deep
IOP		
Optic Disc		
Macula		
Periphery		

Please summarise any relevant medical history. *(including details of past vitrectomy, co-morbidities and anaesthesia history):*

Current medication:

Allergies (general & medication)

Any other comments:

Special requirements:
☐ Interpreter- language:
☐ Signer ☐ Hearing devices
☐ Transport - entitled to PTS? ☐ Yes ☐ No

I confirm that the above named patient is visually disabled by symptoms of Cataract and would like to be considered for Cataract Surgery. *Please refer to our website for details of our exclusion criteria.*

Signature of referring practitioner: ______________________________

Please fax referral to: **01634 364 842** or post to:

The Bookings Team, Will Adams NHS Treatment Centre, Will Adams NHS Treatment Centre, Beechings Way, Gillingham ME8 6AD